Note

[1] http://jiddu-krishnamurti.net/en/commentaries-on-living-series-1/1956-00-00-jiddu-krishnamurti-commentaries-on-living-series-1-58-fear

References

1. National Centre for Disease Control. Seasonal influenza (H1N1) cases—State/UT wise, Year-wise number of cases, deaths from 2013 to 2020 (till 23rd February, 2020). New Delhi: NCDC, MoHFW; 2020[cited 2020 Mar 31]. Available from: https://ncdc.gov.in/showfile.php?lid=280
2. National Vector Borne Disease Control Programme. Diseases. New Delhi: NVBDCP, MOHFW; 2020 [cited 2020 Mar 31]. Available from: https://nvbdcp.gov.in/index4.php?lang=1&level=0&linkid=407&lid=3683
3. Million Death Study Collaborators; Bassani DG, Kumar R, Awasthi S, Morris SK, Paul VK, et al. Causes of neonatal and child mortality in India: A nationally representative mortality survey. *Lancet*. 2010 Nov 27; 376 (9755):1853–60.doi:10.1016/S0140-6736(10)61461-4.
4. Callaway E, Cyranoski D, Mallapaty S, Stoye E, Tollefson J. The corona pandemic in five powerful charts. *Nature News*. 2020 Mar 18[cited 2020 Mar 31]. Available from: https://www.nature.com/articles/d41586-020-00758-2
5. Central TB Division. India TB Report 2019. Revised National Tuberculosis Control Program. New Delhi: MoHFW; 2019 [cited 2020 Mar 31]. Available from: https://tbcindia.gov.in/index1.php?lang=1&level=1&sublinkid=4160&lid=2807
6. Stop TB initiative. Global report on tuberculosis vaccines. 2018 [cited 2020 Mar31]. Available from: https://www.who.int/tb/publications/global_report/gtbr2018_main_text_28Feb2019.pdf
7. LaBeaud AD, Aksoy S. Neglected funding for vector-borne diseases: A near miss this time, a possible disaster the next time. *PLoS Negl Trop Dis.* 2010 Oct 26; 4(10): e847.
8. Trouiller P, Olliaro P, Torreele E, Orbinski J, Laing R, Ford N. Drug development for neglected diseases: a deficient market and a public-health policy failure. *Lancet*. 2002 Jun 22; 359(9324):2188-94.
9. Pharmaprojects. Pharma R&D Annual Review 2019. Pg 14-18. Available from: https://pharmaintelligence.informa.com/~/media/informa-shop-window/pharma/2019/files/whitepapers/pharma-rd-review-2019-whitepaper.pdf
10. Bajpai V. The challenges confronting public hospitals in India, Their origins, and possible solutions. *Advances in Public Health*. 2014 Jul 13[cited 2020 Mar 31]. Available from: https://doi.org/10.1155/2014/898502
11. Stevens P. Diseases of poverty and the 10/90 gap. 2004 Nov [cited 2020 Mar 31]. https://www.who.int/intellectualproperty/submissions/InternationalPolicyNetwork.pdf

---

Ethics in the Covid-19 emergency: Examining rationing decisions

DOI:10.20529/IJME.2020.049.

Keywords: *Health care rationing, patient selection, health system resources, ethics, decision making***.**

> "*Place age limit for access to intensive care, [that is] based on greatest possibilities of survival.*"

Early last month, the Italian Society of Anaesthesia was forced to publish the above guideline (1) for the country's hospitals. Besides the rising cases of infection, the doctors realised that patients required up to 15-20 days of intensive care as the disease progressed (2). In the face of medical resource scarcities, the guideline established that everyone could not be saved from the coronavirus. And a massive death toll ensued. Yet, the challenge of taking on the coronavirus appears to be greater for the developing world. In comparison to the developed countries, resource scarcities in the developing countries are far more glaring. Due to a weaker state apparatus, the family's dependence on its providers is greater. Overall, the stakes are high. In this context of an absent social, economic and psychological safety net, this letter argues that rationing decisions should include other non-medical concerns and be made explicit in situations where all else is equal in terms of the ability to benefit from the treatment.

Rationing in healthcare

Broadly speaking, rationing in medicine refers to the denial of treatment to someone who can benefit from it (3). When the demand for healthcare exceeds its supply, rationing decisions are unavoidable. Traditionally, rationing has been implemented based on the ability to benefit from treatment. However, the present surge in demand for healthcare will mean a greater denial of treatment to potential patients. The following challenges highlight why both medical and non-medical reasons could play an important role in healthcare rationing.

Existing challenges: India

Although the Indian government has moved fast to curb its spread, there are, as on April 17, 13000+ cases of the coronavirus in the country. It is also likely that community transmission of the virus already exists in certain areas. Due to India's high population density and the prevalent community-based lifestyle, it is feared that social distancing measures are unlikely to be as effective. In the absence of large scale testing, it is possible that the true number of cases will remain unknown, and even multiply.

Healthcare delivery and utilisation

From a healthcare delivery perspective, there is a critical shortage of resources. Roughly, there is one bed for every 1000 people in the country. The highest positive estimate is that there are about 57,000 ventilators in the entire country in total (4). On top of that, social and economic challenges underlie healthcare utilisation and access. As in other developing countries, the medical system favours those who are rich and well connected. In addition, social stigma with regard to infectious diseases prevents the sick from seeking care.

Consequences for the household

Besides its health system related issues, India lacks the resources for the provision of social security mechanisms. Families excessively rely on income earners for financial support. If the sole breadwinner fails to receive treatment, the entire household could collapse.

Rationing decisions

Given these challenges, rationing decisions in the country need to be well thought out. Especially because a number of hospitalised patients are young, and even children. To those affected, immense emotional and financial losses are caused because of these decisions. Besides medical reasons, age-based and financial factors could help decide whose lives matters most in the face of these rationing decisions. This is especially important in the absence of a social, economic and

psychological safety net. In this context, the following rationing scenarios are presented below:

- *A fair innings*: Williams (5) developed the "fair innings approach" in which he argues for placing a higher value to the lives of the young. Using a sports analogy, he argued that those who have already lived a long life (had a fair innings) need to be given less value than someone who has not yet lived his life. Other than the potential to benefit from the treatment, age-related weightage guides the triage of patients so that young patients can have a fair innings.
- *Providers of the family*: World Bank policies argue for a higher weightage for the lives of those who are in the 30-40 age range as they work and sustain their families (6). They provide for both the young as well as the old. In this way, the entire family is dependent on them. Loss of their lives would put their entire families in financial distress.
- *The less well off*: Since the poor and less well-off are in poor health, and as it is possible that they are more likely to be infected, leading to potential death from the virus, it makes sense to prioritise their treatment. In the Indian context, the less well-off also live in conditions where it is possible for them to spread the virus to others in the area who are also in poor health. Treating them could mean potentially saving the lives of others who would come in contact with them. From both a utilitarian and social justice perspective, it is essential to treat the less well-off to stop the virus.

In conclusion, it is possible that some hard rationing decisions would be made to treat coronavirus patients in the coming times. From an ethical perspective, one needs to look at these considerations to make sound rationing decisions. Whatever those decisions may be, decision makers would need to explain the trade-offs in an explicit and rational way in order to prevent worsening the impact of the virus. In doing so, a wider public debate needs to be carried out to help guide such important decisions.

Arnav Mahurkar *(arnavmahurkar@gmail.com**),** MSc Student, Health Economics, Policy and Law, Erasmus University Rotterdam, THE NETHERLANDS*

References

1. Feigl-Ding E. ICU rationing+ Prioritization beginning in Italy. *Twitter.com*. 2020 Mar 8[cited 2020 Apr 10]. Available from: https://twitter.com/drericding/status/1236508490488741889?lang=en
2. Rosenbaum L. Facing Covid-19 in Italy — Ethics, logistics, and therapeutics on the epidemic's front line. *N England J Med*. 2020 Mar 18. doi: 10.1056/nejmp2005492. Epub-ahead of print.
3. Scheunemann LP, White DB. The ethics and reality of rationing in medicine. *Chest*. 2011Dec; 140(6), 1625–32. doi: 10.1378/chest.11-0622.
4. Singh P, Ravi S, Chakraborty S. COVID-19: Is India's health infrastructure equipped to handle an epidemic? *Brookings.edu.blog*. 2020 Mar 24[cited 2020 Apr 8]. Available from: https://www.brookings.edu/blog/up-front/2020/03/24/is-indias-health-infrastructure-equipped-to-handle-an-epidemic/
5. Williams A. Intergenerational equity: An exploration of the 'fair innings' argument. *Health Economics*. 1997 Mar-Apr;.6(2), 117–32.
6. Wagstaff A. QALYs and the equity-efficiency trade-off. *J Health Econ*. 1991 May; 10(1), 21–41. doi: 10.1016/0167-6296(91)90015-f.

Dealing with Covid -19: Lessons from China

DOI:10.20529/IJME.2020.050.

***Keywords**: Covid-19, China, authoritarian state, mass quarantine, public health investment*

"If the officials had disclosed information about the epidemic earlier, I think it would have been a lot better. There should be more openness and transparency" - Dr. Li Wenliang (1986- 2020) in an interview to New York Times

Gopichandran and Subramaniam in their editorial in *IJME* have appreciated the intensive Chinese efforts to contain the Covid-19 outbreak and wondered if other "weak" and developing health systems will be able to do the same (1). In a section of their editorial, "Strengthening health governance and law", they appreciate the efforts of authoritarian state China to make mass quarantine possible. They go on to write, "A mass quarantine of the proportions seen in China is very difficult to achieve in India". While everybody should get appreciation when it is due, if we don't distinguish between different components of a system, our conclusions may not be correct. Here we need to distinguish between China's authorities and its healthcare workers.

The WHO Chief praised Chinese authorities at the end of January (2) and that may have inspired the authors to note it in their editorial. But we need to realise that that claim has been questioned by many (3, 4). Moreover, the memory of Dr Li Wenliang should haunt us if we believe such claims. The brave doctor tried to raise awareness about an emerging infectious disease in his closed group to warn others to protect themselves. In response, he was silenced by the authoritarian State (5), after which he kept on working in hospital, contracted the same infection and then succumbed to it. All of us need to draw some courage and inspiration from his heroism. Besides, a careful analysis of the situation may bring us some new and useful insights

Healthcare reforms introduced in China since 2008 have transformed its delivery system (6). Scholars at the Harvard School of Public Health emphasise China's efforts to make extensive primary care system available to the masses. A World Bank graph depicting rising life expectancy at birth of the Chinese population shows a steady improvement in this century (7). A plateau in the latter part of the last century is attributed to the government's efforts then to privatise the healthcare system before that. Hence it would be preferable to appreciate authorities only when it is deserved. The irony is that while China is reaping the rich dividends of its early and substantial investment in public health, our Government is privatising its public services at a rapid pace. Right now, it is planning to give its district hospitals into private hands (8). Hence we need to introspect and carry out a course correction here. We earnestly urge our policy makers to learn from China on how, by expanding Universal Health Care, one can achieve a healthy population - and healthy workers - who can fuel the economy by providing a strong labour force.